Shepherdsville Chiropractic & Rehab ~ 149 Highway 44E ~ Shepherdsville, KY 40165 ~ (502)543-2225 ~

CASE HISTORY

Full Name: _____ Date of Birth: _____ Chart #: _____

History of Present Injury / Illness List the complaints you are here to have treated, in order of importance & list how long you have had each:

1. _____ How Long? _____ 2. _____ How Long? _____
3. _____ How Long? _____ 4. _____ How Long? _____
5. _____ How Long? _____ 6. _____ How Long? _____

Please fill out the following for the primary condition for which you are here to be treated:

Circle the number that best matches your level of pain at its worst. (0=no pain, 10=most severe) **0 1 2 3 4 5 6 7 8 9 10**

1. Is your condition related to an accident? ☐ Yes ☐ No If yes: Date of Accident _____ ☐ Work Related ☐ Other
2. How did pain or condition start? _____ When did it start? _____
3. What words **best describe** your present condition? (example: sharp, burn) _____
4. **When** is your condition ***most*** severe? _____ **least** severe? _____
5. What makes your condition feel worse? _____ feel **better**? _____
6. What activities are difficult because of your condition? _____
7. Have you seen any other health care provider for your present condition? ☐ Yes ☐ No If yes, who? _____
8. Personal Habits: ☐ Tobacco ☐ Alcohol ☐ Vitamins ☐ Exercise ☐ Recreational Drugs ☐ Medications & Reasons _____
9. Family history related to present condition: _____

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time.

Female History: **Are you pregnant at this time?** ☐ Yes ☐ No ☐ Unsure but could be

Date of last menstrual cycle _____ ☐ regular ☐ irregular Using birth control pills: ☐ Yes ☐ No

Are you experiencing or do you have any of the following: (check all that apply)

☐ A sore that won't heal	☐ Difficulty swallowing	☐ Persistent cough / hoarseness	☐ **None of the above**
☐ Any bleeding / discharge	☐ Lump / thickening anywhere	☐ Wart / mole changes	
☐ Bladder / bowel problems	☐ Night Pain	☐ Weight loss without trying	

Review of Systems

In addition to the symptom(s) / dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System (check all that apply)

☐ Sensory changes	☐ Facial drooping	☐ Loss of balance	☐ Seizures	☐ Headache
☐ Atrophy	☐ Vision trouble	☐ Memory loss	☐ Dizziness	☐ Anxiety
☐ Joint deformity	☐ Mood swings	☐ Speech problems	☐ Twitches	☐ Limited range of motion
☐ Psychiatric disorders	☐ Joint locking	☐ Muscle weakness	☐ Stiffness	☐ Depression
☐ Difficulty walking	☐ Joint swelling	☐ Numbness	☐ Tremors	☐ Concussion
☐ Lack of coordination	☐ Popping noises	☐ Extremity deformity	☐ **None of the above**	

Cardiovascular System (check all that apply)

☐ Ankle swelling	☐ Known vascular disease	☐ Chest pain	☐ Dizziness	☐ Fainting
☐ Mitral valve prolapse	☐ Changes in skin color	☐ Jaw pain	☐ Phlebitis	☐ Pin stroke
☐ carotid blockage	☐ Shortness of breath	☐ Previous stroke	☐ Varicose veins	☐ Blood clots
		☐ Hypertension	☐ **None of the above**	

Past History List any surgeries you have had (including: appendix, tonsils, wisdom teeth. Etc.)

1. _____ When? _____ 2. _____ When? _____
3. _____ When? _____ 4. _____ When? _____

List any hospitalizations other than surgeries, when & for what: _____

List any diagnosed conditions: (examples: diabetes, cancer, etc.) _____

List any current Dr.'s & conditions not previously listed: _____

List any major or minor falls or accidents & when they occurred: _____

List any cracked or broken bones & when they occurred: _____

Patient's Signature _____ Date _____

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